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ABSTRACT

This digest describes the characteristics and extent of anorexia and bulimia, and provides psychosocial and family profiles of the victims. The role of counseling programs in treating these disorders is discussed. (BH)

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IN BRIEF

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An Information Digest From ERIC/CAPS
Educational Resources Information Center
Counseling and Personnel Services

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Eating Disorders: Counseling Issues

Bulimia and anorexia are binge-eating and starving disorders that afflict thousands of adolescent and young adult women each year. This digest describes the characteristics and extent of the disorders, a psychosocial and family profile of the victims, and the role of counseling programs in their recovery.

Characteristics of Bulimia and Anorexia

Diagnostic criteria established in 1980 by the American Psychiatric Association include the following:

Bulimia. (1) Recurrent episodes of binge-eating. (2) Awareness that the eating pattern is abnormal and fear of being unable to stop voluntarily. (3) Depressed mood and self-deprecating thoughts after binging.

The majority of bulimics binge in secret and resort to self-induced vomiting or purging. A typical binge averages 4,000 calories, lasts an hour, and occurs twice a day.

Anorexia. (1) A 25% weight loss or a body weight 25% below normal. (2) Intense fear of becoming obese, which does not diminish as weight loss progresses. (3) Distorted body image, claiming to feel fat or "just right" even when emaciated. (4) Refusal to maintain weight above a minimum norm for age and height.

Anorexics may also binge/purge and abuse physical exercise. Usually, they suffer from more severe psychological and medical problems than bulimics.

Extent of Bulimia and Anorexia

Estimates of the extent of eating disorders range from 500,000 for bulimia and anorexia combined to 5 million for bulimia alone. Estimates of incidence also vary, from 3.8% to 13% for bulimia and .6% to 11% for anorexia. The lack of consensus on data derives from variables inherent in victims' self-reports, an inconsistency among operational definitions of the disorders, and the differences between clinical and non-clinical populations.

Psychosocial Profile

The typical image of the eating disordered is the "model child" or "perfect little Princess," but behind this lies a poor sense of self, an intense need for approval, and compulsive high-achievement. Because flaws are seen as failures, which in turn invite rejection, a pervasive anxiety dominates their lives. To cope socially, bulimics tend to be gregarious impression-managers, while anorexics may simply withdraw.

The wider context for these disorders, according to some theorists, is women's social dependency in a culture that idealizes thin female bodies. In this view, dependency defines females in terms of "other" rather than "self," making them highly responsive to external demands and rewards, less likely to develop internal resources, and especially vulnerable to perceived failure and rejection.

Family Profile

Bulimics and anorexics typically come from families who depend excessively on each other and cannot handle stress and anger. "Enmeshed" is an apt description: what they consume, wear and do, and how well they appear, behave and perform are all regarded as everybody's business and extremely important.

Paradoxically, the eating disorder functions to preserve family stability. The victim secures some sense of identity, approval and control through the special attention her illness requires, and other members acquire a unifying focus for their own roles. The net effect is to reinforce the family's mutual dependencies and hide underlying conflicts.

Role of Counseling Programs

Multidisciplinary intervention programs that offer individual and family or group counseling, as well as adjunct self-help or support groups, can help the recovery of significant numbers of the eating disordered. The most successful program combines individual with family counseling and uses a team approach that includes a physician and nutritionist. Chemical dependency programs often provide useful models. The core elements of the three types of counseling consist of the following:

Individual counseling. (1) Journal keeping. (2) Nutritional intervention. (3) Altering antecedent events. (4) Utilizing cognitive-behavioral techniques. (5) Manipulating consequences. (6) Eliciting the support of family and friends.

Family counseling. (1) Discussing realistically how the disorder affects each member. (2) Designing tasks to fit the developmental level of each member. (3) Providing alternate ways to respond to the illness. (4) Establishing rules of eating conduct to clarify areas of control and responsibility. (5) Helping members meet each other's emotional needs. (6) Looking for abusive or addictive patterns in other members.

Group counseling. (1) Educating the group on family dynamics, dependency, stress management, nutrition, women's issues, depression, feelings, sexuality and assertiveness. (2) Utilizing a mix of therapeutic devices, such as rational-emotive techniques, Gestalt and process techniques, spiritual counseling, neurolinguistic programming, behavior modification, desensitization and confrontation.

Among client populations of bulimics, 63% to 80% eventually become binge/purge-free; among anorexics, 50% regain normal weight and eating habits, 25% improve but have pronounced weight and/or eating habit problems, and 25% are resistant to intervention. Early identification and treatment are crucial to a successful outcome for both disorders.

Compiled by Deborah Herbert, Editor, ERIC/CAPS

List of resources available upon request.

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